Enhancing the Safety of Referrals to Jordan Valley Medical Center of Women with a Planned Out-of-Hospital Birth

A. Referral Arrangements

1. Patient with non-urgent problem, not in labor (e.g. suspected IUGR, suspected anomaly, malpresentation, post-dates).
    a. The referring midwife will call the Labor and Delivery Unit of the hospital (801-601-2315) and asked to speak to the Charge Nurse who will receive the information. If indicated the Charge Nurse will direct the midwife to send the patient to labor and delivery for immediate assessment. The Charge Nurse will notify the on-call physician of the impending admittance to JVMC.
    b. If the patient is to go to labor and delivery, see #2.
2. Patient in labor or who requires urgent or emergent referral to Labor and Delivery at JVMC.
    a. The referring midwife will decide the best method of transport of the patient to the hospital. This might be by ambulance or private car.
    b. The referring midwife will call the Charge Nurse in Labor and Delivery at 801-601-2315.
    c. The Charge Nurse will determine who will be the accepting provider, according to the OB on-call schedule listed in the nurse's station.
    d. The Charge Nurse will obtain identifying data of the patient, the name and contact information of the referring midwife and a description of the reason for referral.
    e. The charge nurse will request that the referring provider complete and fax to labor and delivery (801-601-2655) a copy of the prenatal record and the form "Maternal Transfer to Hospital: Provider-to Provider Report" obtainable online at http://health.utah.gov/uwnqc. Left hand side click the following: Current Projects, > Out-of-Hospital Birth, > Out-of-Hospital Birth Resources, > Maternal Transfer Form, > Printable UWNQC Maternal Transfer Form. This form contains key medical information about the patient and the referring midwife's contact information. As an alternative to fax, the prenatal record and the Provide-to-Provide report may be brought to labor and delivery by the patient.
    f. The Charge Nurse will notify the accepting provider of the referral, and convey the patient information they received as well as the referring midwife's contact information.
    g. If possible, the accepting provider will call the referring midwife to obtain a report. This telephone report will supplement the written Maternal Transfer to Hospital; Provider-to-Provider Report.
    h. The accepting provider assumes responsibility for the patient once she arrives at the hospital.
    i. This process is the same for postpartum referral to Labor and Delivery for non-emergent conditions that are best handled in this setting (e.g. laceration repair, suspected preeclampsia).

3. Delivered patient who requires urgent transport to the Emergency Department for conditions such as hemorrhage, eclampsia, infection, or preeclampsia with severe features:
    a. The referring midwife will decide the best method of transport of the patient to the hospital. This might be by ambulance or private car.
    b. The personnel in the ED will notify the OB/Gyn emergency on call to assist in the care of the patient, as needed.
    c. If admission to the hospital is needed (other than to an ICU) the patient will be admitted to the OB/Gyn emergency on call.
4. Communication with the referring provider:
    a. The "Maternal Transfer to Hospital: Provider-to-Provider Report" (see 2e) should include the telephone number and address of the referring midwife.
    b. The hospital provider ultimately caring for the patient will notify the referring midwife of the patient's hospital course by telephone.
    c. A discharge summary will be mailed to the referring midwife.

B. Topics a referring midwife may want to address with a patient prior to an intrapartum referral:
1. Reason for referral.
2. Method of transport and unit to which they should go.
    a. If the patient is going by private car, she should be given directions to the receiving unit.
3. Discussion of interventions that may be recommended at the hospital, depending on the reason for the referral and the patient's status after arrival at the hospital.
    a. For laboring patients, usual care includes;
        i. Complete review of the patient's history and performance of physical exam.
        ii. Placement of an IV and administration of IV fluids.
        iii. Continuous fetal heart rate monitoring.
        iv. Birth in a labor and delivery room or Women's Center OR.
        v. Dependent on baby's status immediate skin-to-skin contact between mother and baby.
        vi. Dependent on baby's status immediate opportunity to breast feed.
        vii. Vitamin K administration, antibiotic eye prophylaxis.
        viii. Discussion between JVMC provider and patient regarding all proposed interventions.
    b. Procedures that are NOT commonly used:
        i. Enema.
        ii. Episiotomy.
        iii. Dependent on baby's status immediate separation of the mother from the baby is baby is stable.
    c. Options that are usually available, depending on the patient/baby status, patients' desires and discussions with provider.
        i. Epidural.
        ii. Choice of delivery position.
        iii. Delayed cord clamping.

4. Involvement of others who wish to accompany the patient to the hospital.
    a. The patient may decide who is present for her labor and delivery at JVMC. These may include:
        i. Non-sick siblings of the baby. Because of concerns over viral transmission, in some seasons there may be visiting restrictions of well-children under the age of 12. Children must be supervised by an adult, other than the patient, in the patient room or the waiting room.
        ii. The patient will determine who can be in her room. Patient will give visitors a security number for entry to the Labor/Delivery and Postpartum Units.
    b. There are waiting rooms located within the Women's Center and in the main lobby outside of the Women's Center.
    c. There are no additional restrictions during placement of an epidural.
    d. The patient may choose one person to accompany her if delivery in the operating rooms becomes necessary. In the rare event that the patient has a general anesthetic for a cesarean, the visitor will be asked to leave.
    e. While the referring midwife is welcome to accompany the patient in the hospital, they will not perform the delivery or provide nursing or medical care.

C. Postpartum Care.
1. If postpartum care is required in the first few weeks after delivery (for conditions such as staple removal, wound or BP check), this will be performed by a hospital-based provider.

D. Neonatal Issues.
1. If the baby is born outside the hospital and required hospital evaluation and treatment, but the mother does not require hospital admission or treatment:
    a. The baby should be brought to the NICU.
    b. The referring midwife will call the Charge Nurse in the NICU at 801-601-2319.
    c. The Charge Nurse will determine who will be the accepting provider, according to the Neonatologist on-call schedule listed in the nurse's station.
    d. The Charge Nurse will obtain identifying data of the patient, the name and contact information for the referring midwife and a description of the reason for referral.
    e. The charge nurse will request that the referring provider complete and fax to the NICU (801-601-2676) a copy of the prenatal record and the form "Neonatal Transfer to Hospital: Provider-to Provider Report" obtainable online at http://health.utah.gov/uwnqc. Left hand side click the following: Current Projects, > Out-of-Hospital Birth, > Out-of-Hospital Birth Resources, > Neonatal Transfer Form, > Printable UWNQC Neonatal Transfer Form. This form contains key medical information about the patient and the referring midwife's contact information. As an alternative to fax, the prenatal record and the Provide-to-Provide report may be brought to the NICU by the parents.
    f. The Charge Nurse will notify the accepting provider of the referral, and convey the patient information they received as well as the referring midwife's contact information.

g. If possible, the accepting provider will call the referring midwife to obtain a report. This telephone report will supplement the written Neonatal Transfer to Hospital; Provider-to-Provider Report.
h. The accepting provider assumes responsibility for the patient once baby arrives at the hospital.
i. The baby's care will be established by NICU personnel.

2. If the baby is born outside the hospital, and is well, but the mother requires hospital admission:
   a. It is generally assumed that the baby will be with the mother in the hospital.
   b. Policies regarding the involvement of hospital staff in the observation and care of the baby are not yet in place (there are unresolved logistical and legal issues).
3. If the baby is born in the hospital:
   a. Routine admission and care—the same as with planned in-hospital births.

E. Other Miscellaneous.
1. If there has been a stillbirth, fetal growth restriction or hemorrhage the patient transferred after delivery should bring the placenta in a plastic bag.
2. If a referring midwife has questions or concerns about the operation of this process, they may contact the Director of the Women's Center, Dr. Scott Epstein, OB chair or Dr. Tim LaPine, Neonatologist Chair.